STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155246	A. BUILDING 00 B. WING	06/14/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERS OF DUNELAND, THE	110 BEVERLY DR CHESTERTON, IN46304

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F0000	This visit was for the Investigation of Complaint IN00091519. Complaint IN00091519 substantiated, Federal/State deficiency related to the allegations is cited at F 157. Survey dates: June 13 and 14, 2011 Facility number: 000150 Provider number: 155246 AIM number: 100267000 Survey team: Janelyn Kulik, RN Census bed type: SNF/NF: 93 Total: 93 Census payor type: Medicare: 13 Medicaid: 71 Other: 9 Total: 93 Sample: 7 This deficiency also reflects state findings cited in accordance with 410 IAC 16.2. Quality review completed 6/20/11	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F0157 SS=D	Cathy Emswiller RN A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. Based on record review and interview, the facility failed to ensure the residents physician was notified in a timely manner for 1 of 4 residents with a change in condition in a sample of 7 related to not call the physician when the resident had a low blood sugar.	F0157	Plan of Correction F157The facility does immediately inform the resident, consult with the physician; and if known notify the legal representive or interested family member when there is an accident involving the resident.I. The actions taken by the facility are as follows:Regarding	06/15/2011

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	Findings include: The record for Resident #C was reviewed on 6/13/11 at 12:35 p.m. The resident's diagnoses included, but were not limited to, cerebrovascular accident (stroke), atrial fibrillation, hypertension, and non-insulin dependent diabetes mellitus. A physician order statement dated 5/25/11, indicated blood sugars were to be checked daily at 9:00 p.m. A physician order dated 5/27/11 at 10:00 a.m. indicated, "call MD (physician) if blood sugar < (less than) 60 or > (greater than) 200. A nurse's note dated 5/30/11 at 2:15 p.m., indicated the resident was found unresponsive with a blood sugar of 35. The resident was given one dose of Glucagon (medication to raise blood sugar). The resident's blood sugar slowly rose "49, 50, 108. The resident was also given orange juice with sugar. The resident was able to swallow. The resident opened his eyes and was non-verbal. His oxygen saturations was 86%, blood pressure was 87/60, pulse 72, respirations 20, and temperature 97.5. The resident's daughter was notified at 1:00 p.m. The daughter wanted the		Resident C was sent out to the hospital on 5/30/11.II. The facility's actions taken to identify other residents are as follows:100% review of all residents for low blood sugars below parameters were reviewed by DON and no further issues found.III. The measures put into place by the facility are as follows:The licensed nursing staff was reinserviced on notifying physicians in a timely manner for low blood surgars and physicians notification of alert glucose monitoring form.The DON and/or designee will review all residents who recieve insulin for low blood sugars, timely physicians notification and alert glucose monitoring form daily.IV. The facility will monitor actions as follows:The DON and/or designee will review all residents who recieve insulin for low blood sugars, timely physician notification, and alert glucose monitoring form daily.The Quality Improvement committee will determine the end date for the audits.	

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	resident sent to the emergency room for evaluation and treatment. Oxygen was applied to the resident at 4 liters per nasal canula. The resident's blood sugar was rechecked at 1:30 p.m. and it was down to 42. The resident opened his eyes but was non-responsive verbally. The physician was notified and gave an order to transfer the resident to the emergency room. Review of the 5/25/11 Physician Order Statement, indicated there was no order for Glucagon. The Guidelines for Treatment of Hypoglycemia (low blood sugar) was provided by the Director on Nursing on 6/14/11 at 8:50 a.m. The policy indicated, "to provided a plan for response to hypoglycemia." The procedure included, but was not limited to: "1. Signs/Symptoms: Tremors, tachycardia, diaphoresis, paresthesia, excessive hunger, pallor, shakiness yet mentally alertness. 2. treatment: 10-15 grams of rapid acting carbohydrates: 4 oz. orange juice, 6-8 oz 2% or skim milk, 3 graham crackers squares, 6 jelly beans or 2 Tbsp. raisins, 6-8 LifeSavers (or hard candy if resident able to safely swallow), 3 glucose tablets, 6 oz regular soda. 3. wait 15-30 minutes assessing signs and symptoms. If no improvement, call physician for further instructions. 4. Signs/Symptoms:			

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	disorientation, seizure, and unconsciousness. 5. Treatment: Give 1 mg(milligram) Glucagon IM (intramuscularly) or SC Sub-cutaneous) or Insta-glucose-per the physician's orders. Nurse #1 was interviewed on 6/14/11 at 10:20 a.m. The nurse indicated she had taken care of Resident #C on 5/30/11. She indicated she had spoken to the resident's daughter a day or so before and the daughter had indicated she was concerned with how much the resident was eating and being on oral blood sugar medications. She then indicated she had spoken to the CNA who had assisted Resident #C with breakfast and was told the resident had eaten 75 % of his breakfast. She had also been told that the resident was alert and talking during breakfast. Nurse #1 further indicated she had given the resident his medication around 9:00 to 9:30 a.m. and that the CNA had told her twice the resident had a bowel movement. The second bowel movement was at approximately 10:00 a.m. The nurse then indicated around 11:30 to 11:45 the CNA went in to get the resident up for lunch and informed her the resident was unresponsive. The nurse indicated she checked the resident's blood sugar and it was 35. She indicated they sat the resident up and told staff to try some orange juice with sugar while she			

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	got the Glucagon. She indicated Nurse #2 was also helping her. She further indicated she got the resident to drink a little orange juice. She indicated she watched him swallow the juice with no problems. He did not cough or choke. "He was not completely non-responsive." She indicated his blood sugar was rechecked within five minutes and it was starting to go up, it was checked again 5 minutes later and it was a little higher and then again in another 5 minutes. She indicated when the resident was stable she called the resident's daughter and informed her of his condition. Nurse #1 indicated she had told the resident's daughter she thought the resident should go to the hospital. The daughter agreed. Nurse #1 then indicated that was when she notified the physician and received the order to send the resident to the hospital. Interview with Nurse #1 on 6/14/11 at 10:50 a.m., indicated the first time she called the physician was after she had contacted the resident's daughter. She did not try to reach the physician prior to calling the resident's daughter. This Federal tag relates to Complaint IN00091519. 3.1-5(a)(2)			

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